kaiser commission on medicaid and the uninsured

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Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians

Executive Summary

The Patient Protection and Affordable Care Act (ACA) includes two provisions with significant implications for the adequacy of the supply of primary care physicians (PCP) serving Medicaid enrollees. First, the ACA extends Medicaid eligibility to nearly everyone under age 65 up to 133% of the federal poverty level ($14,484 for an individual or $29,726 for a family of four in 2011). The Congressional Budget Office has estimated that 16 million people, mostly adults, will gain Medicaid coverage as a result of this expansion; another 16 million people are projected to gain private coverage through insurance exchanges established by the new law. Second, for 2013 and 2014, the ACA raises Medicaid payment rates for primary care services delivered by PCPs, to Medicare's payment levels for the same services.

While access to primary care among adult Medicaid beneficiaries is generally good, the entry of 32 million newly insured people into the health care system will intensify competition among patients and payers for scarce primary care resources. To help inform policy to ensure adequate access to primary care for Medicaid enrollees, this study provides an assessment of which PCPs are most likely to respond to the changes under health reform by serving additional Medicaid beneficiaries, and it profiles important aspects of their practices.

Study overview and methods

Data for the analysis are drawn from the 2008 Center for Studying Health System Change (HSC) Health Tracking Physician Survey, a nationally representative mail survey of U.S. physicians. The study sample includes 1,460 PCPs (internists, family practice physicians, and general practitioners) who treat adults in outpatient settings. PCPs were classified into four categories based on level of Medicaid participation, as measured by self-reported distribution of practice revenue and acceptance of new Medicaid patients:

- **High-share Medicaid physicians:** PCPs who reported that 26% or more of their practice revenue is from Medicaid.
- **Moderate-share Medicaid physicians:** PCPs who reported that 6% to 25% of their practice revenue is from Medicaid and that they accept at least some new Medicaid patients.
- **High-share Medicare physicians:** PCPs who reported that 26% or more of their practice revenue is from Medicare, they accept new Medicare patients, and they get some of their practice revenue from Medicaid.
- **Low- and no-share Medicaid physicians:** PCPs who do not meet the criteria for either the high- or moderate share Medicaid groups or the high-share Medicare PCP group.

To supplement the quantitative analysis, in-depth telephone interviews were conducted with 15 PCPs recruited from the survey respondents, to gain insights into PCPs' willingness to accept Medicaid patients after health reform, factors that discourage Medicaid participation, and practice resources that affect readiness to manage increased Medicaid demand. Interviewees were recruited from the first three PCP groups as defined in the quantitative analysis, stratified by practice size, type, and region.

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Key Findings

In 2008, the PCPs who served Medicaid beneficiaries most actively were also the most willing to accept new Medicaid patients, and they had substantial resources and capacity to serve low-income adults. However, they also face capacity constraints to serve more of this population.

- **Most high- and moderate-share Medicaid PCPs report accepting new Medicaid patients.** High-share Medicaid PCPs, who account for 19% of all PCPs, are most willing to see new Medicaid patients – the vast majority (84%) report accepting "all" or "most" new Medicaid patients. Over two-thirds (68%) of moderate-share Medicaid PCPs, who make up 29% of PCPs, also report accepting "all" or "most" new Medicaid patients. In contrast, just 20% of high-share Medicare PCPs, who account for 19% of PCPs, accept "all" or "most" new Medicaid patients; half accept none.
- **The PCPs most willing to see new Medicaid patients work in lower-income areas and are more likely to practice in hospital-based settings and community health centers, which are key sites of care for low-income populations. They are also more likely to work in practices owned in part by a hospital.** Median household income in the zip code areas where high- and moderate-share Medicaid PCPs practice is lower compared to areas where high-share Medicare PCPs practice. High-share Medicaid PCPs are much more likely to work in hospital-based offices and community health centers (38%), compared to moderate-share Medicaid PCPs (17%) and high-share Medicare PCPs (6%). About 30% of both high- and moderate-share Medicaid PCPs report that a hospital has an ownership interest in their practice versus 19% of high-share Medicare PCPs who report this arrangement.
- **The majority of PCPs most willing to accept new Medicaid patients use health IT for core patient care purposes.** About three-quarters of high- and moderate-share Medicaid PCPs report using all electronic medical records (EMR) and having IT available for up-to-date decision support in their main practice, and about 60% use IT to access patient notes, medications, and problem lists. These levels are as high as the levels among high-share Medicare PCPs.
- **The PCPs most willing to accept new Medicaid patient often have important patient supports available at their practices.** Nearly 70% of high-share Medicaid PCPs provide interpreter services at their main practice, compared with 45% of high-share Medicare PCPs. They are also significantly more likely to use non-physician staff to provide patient education for people with at least one of four major chronic conditions (56% versus 47%, respectively). Moderate-share Medicaid PCPs resemble high-share Medicaid PCPs on both these practice resource measures.
- **Inadequate access to specialists and time for patient care constrain the capacity of the PCPs most willing to accept new Medicaid patients.** Over a quarter (28%) of high-share and 18% of moderate-share Medicaid PCPs report that lack of qualified specialists in the area is a major problem that limits their ability to provide high-quality care. About 40% of both groups report inadequate time with patients as a major problem. The rates for high-share Medicare PCPs are significantly lower. These findings indicate that the PCPs most willing to see new Medicaid patients nonetheless experience strains on their capacity to provide high-quality care.

Low- and no-share Medicaid PCPs appear to offer less promise of expanding primary care access in Medicaid.

- **Eight in ten low- and no-share Medicaid PCPs accept no new Medicaid patients.** Fully 93% of these PCPs reported that 5% or less of their practice revenue is from Medicaid. These PCPs also limit their participation in Medicare and private insurance – more than one-quarter (29%) accept no new Medicare patients and about one-quarter accept just "some" (15%) or no (9%) new privately insured patients.

- **The practice characteristics of low- and no-share Medicaid PCPs also indicate a lack of "fit" with the newly eligible Medicaid population.** Median household income is distinctly higher in the zip code areas where low- and no-share Medicaid PCPs practice than in the areas where high- and moderate-share Medicaid PCPs practice. Also, compared to high-share Medicaid PCPs, these PCPs are significantly less likely to offer interpreter services and to use non-physician staff to provide patient education.
- **Low- and no-share Medicaid PCPs are less advanced than other PCPs in terms of health IT**. These PCPs are significantly less likely than others to use all electronic medical records at their main practice and fewer use health IT for up-to-date decision support and to access patient notes, medications, and problem lists.

Health reform may change PCPs' willingness to participate in Medicaid and it presents new capacity challenges.

- **In in-depth interviews, high-share Medicaid PCPs express willingness to take as many new patients as they can.** Nearly four in ten (38%) high-share Medicaid PCPs work in hospital-based practices and community health centers, settings that may have the capacity to expand their Medicaid service. However, about one-quarter are in solo or two-physician practices; the additional capacity they can offer will be limited by the additional hours they can work, and patient wait times for an appointment could increase.
- **Moderate-share Medicaid and high-share Medicare PCPs might be willing to increase their participation in Medicaid, and they appear to have the capacity to do so in the short-term.** In in-depth interviews, these PCPs said they expect their practices to revisit their level of participation in Medicaid as the Medicaid payment increase for PCPs and the Medicaid expansion roll out. Some have the infrastructure in place to accept more Medicaid patients, while others indicated they might accommodate more demand from Medicaid by hiring a nurse practitioner or physician assistant. PCPs in group practices reported investments in health IT and other capacity-building activities, such as adding evening and weekend hours and building satellite clinics.
- **Among PCPs who limit their Medicaid participation, low payment, administrative burdens, and difficulty arranging for specialist care all emerge as important reasons.** Almost 90% of the PCPs who accept no or only "some" new Medicaid patients cite inadequate payment as a reason, but an equal share cite more than one reason as a very or moderately important factor in their decision. Three-quarters cite payment delays and billing requirements, and 60% cite the "high clinical burden" of Medicaid patients. In addition to these issues, in-depth interviews with these PCPs pointed to difficulty arranging specialist care as a reason.

Policy Implications

The PCPs most willing to accept new Medicaid patients are those already serving Medicaid disproportionately compared to other PCPs. However, even assuming that these PCPs expand their Medicaid service, other PCPs will also be needed to ensure access to primary care as millions of adults gain Medicaid eligibility beginning in 2014.

The finding that moderate-share Medicaid PCPs resemble high-share Medicaid PCPs on some important measures of practice capacity indicates that they could offer potential to help meet increasing primary care demands in Medicaid. Notably, this group of PCPs is large, accounting for almost one-third of adult-care PCPs. At the same time, they differ from high-share Medicaid PCPs on

certain practice characteristics that might affect their response to Medicaid reforms. Specifically, they are more likely to be in group practices and most are in smaller group practices, whereas high-share Medicaid PCPs are more likely to be in hospital-based practices and community health centers. Different considerations may drive decisions about Medicaid participation in small group practices.

How PCPs who receive a high share of revenue from Medicare but participate little in Medicaid will respond to the Medicaid reforms is difficult to predict. Because these PCPs are largely in solo or small practices, even if they expanded their Medicaid panels, the aggregate impact would be limited. Also, compared to high- and moderate-share Medicaid PCPs, fewer offer certain supports that are important for many low-income patients. Further, because they practice in higher-income areas, high-share Medicare PCPs may be less accessible to Medicaid enrollees.

Finally, ongoing, system-wide changes in the organization of primary care delivery could affect which PCPs are willing and have the capacity to serve more Medicaid beneficiaries. For example, given that PCPs with larger Medicaid practices now are more likely than others to be hospital-affiliated, the emerging trend toward hospital acquisition of primary care practices documented elsewhere could lead to more practices expanding their Medicaid service. The degree to which changes like this take hold beyond a few local markets, and the impact of such changes on Medicaid participation decisions, still remain uncertain and merit monitoring.

Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians

Introduction

The Patient Protection and Affordable Care Act (ACA) includes two major provisions with implications for the adequacy of the supply of primary care physicians (PCP) serving Medicaid beneficiaries. The new law extends Medicaid eligibility to nearly everyone under age 65 up to 133% of the federal poverty level (FPL).[1] The Congressional Budget Office estimated that 16 million people, mostly adults, will gain Medicaid coverage as a result (Congressional Budget Office 2010). In addition, the ACA temporarily (in 2013 and 2014) raises Medicaid payment rates to Medicare payment levels for primary care services delivered by PCPs. Low Medicaid payment rates are considered to be the chief reason that fewer physicians are willing to treat Medicaid patients compared to patients with other coverage (Cunningham & Nichols 2005; Coburn, Long, & Marquis 1999), although many physicians also cite other reasons (Cunningham & O'Malley, 2008; Cunningham & May 2006).

The Medicaid expansion is large enough—a 25% increase in enrollment—that both the market impact and health needs of newly eligible adults could have a greater effect on how physicians view Medicaid than factors considered important today. We can expect that adults who become newly eligible for Medicaid will have very different health needs than currently eligible adults, who are primarily pregnant women, young parents, the disabled, and seniors. Research to date is sparse but indicates that half the adults who will gain eligibility in 2014 are very poor (income below 50%FPL), a third have a diagnosed chronic condition, and many are likely to have pent-up needs for care. (Kaiser Family Foundation 2010a and 2010b). They will also include many relatively healthy adults (Somers, Hamblin, Verdier, & Byrd 2010).

How PCPs will respond to the Medicaid expansion is difficult to project, because people who gain private coverage as the result of federal reform and those newly eligible for Medicaid will compete for their services. Expanded benefits for preventive services under the ACA will also spur demand for primary care. New pressures on the system are gathering amid rising concern that population growth and aging could, by themselves, strain the nation's primary care resources (Colwill, Curtice, & Kruse 2008). As competition for primary care resources intensifies, an assessment of the potential additional PCP capacity available to meet new Medicaid demands for primary care can help to inform planning for the Medicaid expansion.

This study classified PCPs by their level of Medicaid participation and compared them on their reported acceptance of new Medicaid patients and on measures of capacity. This is the first study to examine physician willingness to see Medicaid patients in relation to physician capacity. Descriptive analysis used data from a national survey of physicians and was supplemented by in-depth physician interviews.

Data and Methods

Data Sources. Data for the quantitative analysis are drawn from the 2008 Center for Studying Health System Change (HSC) Health Tracking Physician Survey, a nationally representative survey of U.S. physicians. The sampling frame was all physicians listed in the AMA Masterfile (which includes both AMA members and nonmembers) as of July 2007. The sample used a stratified random sampling design with proportional allocation to 20 strata based on ten regions, and physician classification as a PCP or

specialist according to specialty codes from the AMA file. Implicit stratification procedures were applied to achieve proportional representation by gender, age, practice type, and zip code of the physician's preferred address. The self-administered mail questionnaire was fielded in 2008. A total of 4,720 physicians replied to the mail survey for a weighted response rate of 61.9%. Weighting adjusts for probability of selection and differential survey nonresponse. The Westat IRB approved all survey data collection materials and procedures. Detailed survey methods are documented elsewhere (Strouse et al. 2009).

Sample eligibility. Physicians eligible for the sampling frame must have completed their medical training, practiced within the 50 states and the District of Columbia, and provided direct patient care for at least 20 hours per week. This analysis limited sample to physicians in primary care, defined as a primary specialty in internal medicine, family medicine, or general practice medicine, and excluded pediatricians since the study is concerned with the expansion of Medicaid to more adults and the PCPs who would treat them (n=1,460).[2] Some physicians in the sample may treat both children and adults. Specialty classification was updated from the AMA data file based on physician self-report.

Ranking by Level of Participation in Medicaid. PCPs were classified into four groups based on level of Medicaid participation as measured by self-reported distribution of practice revenue and acceptance of new patients. **High-share Medicaid PCPs** reported 26% or more of their practice revenue from Medicaid – a disproportionate share relative to other PCPs. **Moderate-share Medicaid PCPs** reported 6% to 25% of their practice revenue from Medicaid and excluded PCPs accepting no new Medicaid patients. **High-share Medicare PCPs** reported 26% or more of their practice revenue from Medicare and accepting new Medicare patients, and reported non-zero Medicaid revenue; they did not meet the criteria for either high- or moderate-share Medicaid PCPs.[3] **Low- and no-share Medicaid PCPs** represent remaining the PCPs in the sample, who did not satisfy any of the criteria above.

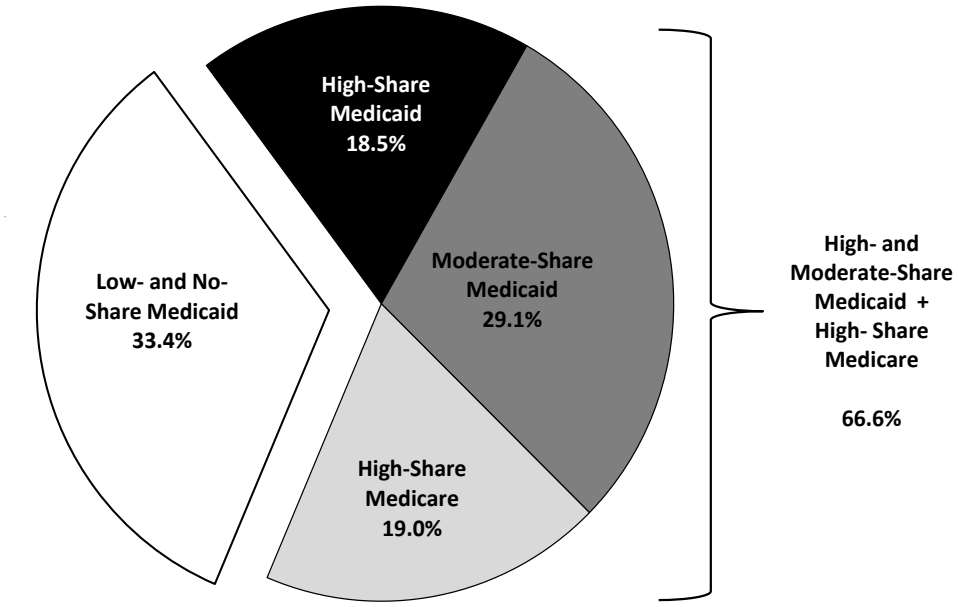
Methods. PCP subgroups were compared on capacity measures available from the survey, including physician and practice characteristics, health IT, non-physician patient supports, and reported problems limiting physician's ability to provide high-quality care. Analysis was conducted in SAS v9.2. Differences were tested for statistical significance using t-tests in SUDAAN that accounted for the complex survey design. All results presented in the text were significant at $p<.05$.

Qualitative Analysis. In-depth telephone interviews were conducted with 15 PCPs in July and September, 2010 to gain insights into PCPs' willingness to accept Medicaid patients now and after health reform, factors that discourage Medicaid participation, and practice resources that affect their readiness to manage increased demand. Interviewees were recruited from the first three PCP subgroups defined above, stratified by practice size, type, and region. PCPs were recruited across strata until 15 interviews were completed. Participants included five high-share Medicaid PCPs (two hospital-based, one solo practice, two group practices), four moderate-share Medicaid PCPs (one solo practice, three group practices), and six high-share Medicare PCPs (three medium-sized group practices, three solo/two-physician practices), representing all four regions of the country and various markets as self-reported (low-income urban, small town, suburban middle-income).

Results

Level of Medicaid Participation. High-share Medicaid PCPs accounted for 18.5% of all PCPs nationally (Fig.1). Moderate-share Medicaid PCPs accounted for 29.1% and high-share Medicare PCPs accounted for 19.0%. Together, these physicians comprised two-thirds of PCPs nationally, while low and no-share Medicaid PCPs accounted for one-third.

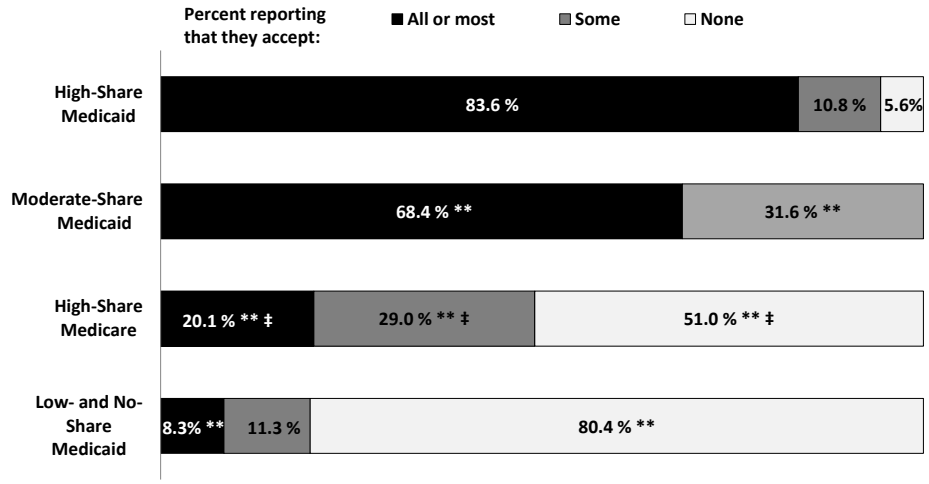
Fig. 1
Percent Distribution of Primary Care Physicians by Level of Medicaid Participation, 2008



Note: Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.
Source: 2008 HSC Health Tracking Physician Survey

High-share Medicaid PCPs are the most willing of all PCPs to see new Medicaid patients. Almost all (83.6%) reported accepting "all" or "most" new Medicaid patients (Fig.2). Many of these PCPs (86.7%) also reported accepting "all" or "most" new Medicare patients (Appendix Table 1). Among moderate-share Medicaid PCPs, 68.4% reported accepting "all" or "most" new Medicaid patients. Only 20.1% of high-share Medicare PCPs reported accepting "all" or "most" new Medicaid patients.

Fig. 2
Acceptance of New Medicaid Patients by Primary Care Physicians by Level of Medicaid Participation, 2008



Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.
Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at †p<.05 and ‡p<.01.
Note: Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.
Source: 2008 HSC Health Tracking Physician Survey

Eight in ten (80.4%) low- and no-share Medicaid PCPs reported that they accept no new Medicaid patients, while 11.3% reported accepting "some," and 8.3% "all" or "most." Notably, low- and no-share Medicaid PCPs also limit their participation in Medicare and private insurance – more than one-quarter (29.1%) reported accepting no new Medicare patients and about one-quarter accept just "some" (15.4%) or no (9.4%) new privately insured patients. Fully 93% of low- and no-share Medicaid PCPs reported that 5% or less of their practice revenue is from Medicaid (Appendix Table 2). About half (51.5%) of these PCPs practice predominantly in the private market, receiving 25% or less of their revenue from public sources. PCPs overall report a more balanced mix of public and private revenue – 60% receive between one-third and 80% of their revenue from public sources (data not shown). These, along with other results (data not shown), suggest that low- and no-share Medicaid PCPs may offer less promise for expanding the Medicaid PCP workforce. In particular, they practice in the highest-income zip code areas and are less likely than other PCPs to use health IT and to offer patient education for people with major chronic conditions. For brevity, these PCPs are omitted from further discussion, but results are available from the authors.

Setting Limits on Seeing Medicaid Patients. The in-depth telephone interviews with PCPs provided new insights into how physicians set limits on Medicaid participation and considerations underlying these decisions. At the time of interviews, in 2010, seven participants said they accepted "all" or "most" new Medicaid patients, and eight said they accepted "some" or "none." The PCPs interviewed described adopting one of two business strategies if they accepted any new Medicaid patients. Some PCPs accepted "all" or "most" new Medicaid patients, explaining that their practices set no limits on how many Medicaid patients they see. Most of these were high-share Medicaid PCPs located in lower-income areas. However, two PCPs with low practice revenue from Medicaid also took this approach; these physicians described their service area as "middle income" and likely faced lower Medicaid demand.

Other PCPs interviewed who were accepting "some" Medicaid patients described different approaches to limiting the number of Medicaid patients seen, stemming from hospital affiliation, ownership structure, and physician agreements for compensation within group practices. In three practices, each with more than two physicians, decisions were made, respectively, by a CEO of a multispecialty group, the hospital partner of a practice, and an individual PCP in a mid-sized group practice who chose to take a few severely disabled individuals referred by the state. One PCP in a large (>50) multispecialty practice described an agreement among her colleagues to limit Medicaid to 10% of each physician's panel because they shared equally in overhead costs. Another practice contracted with one of the state's two Medicaid plans, and still another contracted with the Medicaid managed care plan that paid the highest rate.

Factors That Discourage Medicaid Participation. Among PCPs responding on the mail survey that they accepted only "some" new Medicaid patients or "none," the vast majority (90.5%) cited more than one reason as a very or moderately important factor in their decision (Table 1). The most common reason cited was inadequate reimbursement (89.4%), but three-fourths also cited "delayed reimbursement" and "billing requirements." The "high clinical burden" of Medicaid patients was cited less often, but still by a majority of PCPs.

Table 1
Reasons for Primary Care Physicians' Decisions to Accept "Some" or No New Medicaid Patients

	Physicians reporting reason as very or moderately important (%)
Inadequate reimbursement	89.4
Delayed reimbursement	75.7
Billing requirements	76.2
High clinical burden	60.1
Practice already has enough Medicaid patients	56.0
More than one of these reasons	90.5

Note: Sample excludes pediatricians, and physicians who work most hours on hospital staff or in emergency room.
Source: 2008 HSC Health Tracking Physician Survey

In interviews, too, PCPs accepting only "some" or no new Medicaid patients identified Medicaid payment levels as very important in their participation decision, but low reimbursement was often mentioned in conjunction with the burden that physicians faced from various program and patient-related tasks. The issue most often cited after payment levels was the time-intensive burden of finding specialists to see Medicaid patients, which made it difficult to care adequately for Medicaid patients. (This concern was not among the response options offered for the question posed in the mail survey.)

Other reasons cited included prior authorization, restrictions on prescriptions, and the illness burden and psycho-social needs of the Medicaid population. But PCPs were not uniform in their perspectives on these points. Several did not view Medicaid patients as being any sicker than others they see, noted that Medicare patients are much sicker, or thought the Medicare program was a bigger hassle.

Capacity to Treat More Medicaid Patients

Physician Characteristics. High-share Medicaid PCPs were just as likely as PCPs in the other two groups to be board-certified in their specialty (Table 2). High- and moderate-share Medicaid PCPs were similar across most other personal characteristics. High-share Medicare PCPs were slightly older and had practiced longer on average. A larger percentage of high-share Medicaid PCPs reported compensation based on fixed salary (42.8%), while moderate-share Medicaid and high-share Medicare PCPs were more likely to receive other types of compensation, such as salary adjusted for performance and share-of-practice billing or workload.

Table 2

Characteristics of Primary Care Physicians by Physician's Level of Medicaid Participation, 2008

	High-Share Medicaid	Moderate-Share Medicaid	High-Share Medicare
Physician Demographics			
Years in practice (mean)	15.1	16.9 *	19.3 ** †
Physician age (mean)	48.5	49.2	51.2 ** †
Board-certified in specialty (%)	85.6	88.7	90.0
Medical training in US/Canada (%)	60.7	72.5 **	74.1 ** ‡
Primary Specialty (%)			
Internal medicine	36.7	43.0	63.4 ** ‡
Family/general practice	63.3	57.0	36.6 ** ‡
Basic Compensation Method (%)			
Fixed Salary	42.8	25.4 **	20.4 **

Note: Samples exclude pediatricians and physicians who work most hours on hospital staff or in emergency room.
Difference from high-share Medicaid physicians is statistically significant at *p<.05 and **p<.01.
Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at † p<.05 and ‡ p<.01.
Source: 2008 HSC Health Tracking Physician Survey

Practice Characteristics. High-share Medicaid PCPs practice in different settings than other PCPs (Table 3). Almost four in ten high-share Medicaid PCPs work in hospital-based practices[4] (19.8%) or community health centers (18.2%). Moderate-share Medicaid PCPs are less likely to work in these settings, and more likely to work in small and mid-sized group practices and group/staff-model health maintenance organizations (HMO). However, close to 30% of both high- and moderate-share Medicaid PCPs work in practices where a hospital has an ownership interest. High-share Medicare PCPs are less

likely to work in such practices (18.6%); they are also more likely to work in solo/two-physician practices. Finally, high-share Medicare PCPs practice in zip code areas with higher median household income than high-share Medicaid PCPs, suggesting that they practice farther away from the lower-income communities where Medicaid patients are likely to live.

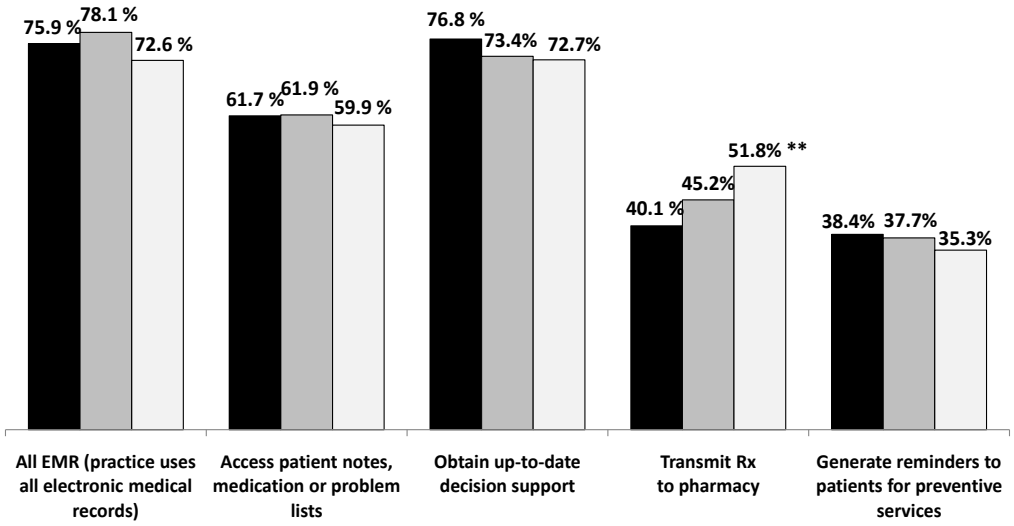
Table 3
Practice Characteristics of Primary Care Physicians by Physician's Level of Medicaid Participation, 2008

	High-Share Medicaid	Moderate-Share Medicaid		High-Share Medicare	
Ownership of practice (%)					
Hospital has an ownership interest	28.7	30.9		18.6	** ‡
Type of practice (%)					
Solo/2 physician	26.3	31.9		43.8	** ‡
Small group (3-10 physicians)	13.4	20.2	*	24.2	** †
Mid-size group (11-50 physicians)	6.0	10.3	*	10.1	†
Large group (50+ physicians)	7.0	9.7		9.1	
Group or staff model HMO	1.7	5.7	**	4.3	‡
Hospital-based practice	19.8	12.9	*	5.6	** ‡
Community health center	18.2	3.8	**	0.3	** ‡
Other	7.7	5.5		2.6	**
Geographic Characteristic of Main Practice					
Median income of zip code (average)	$52,987	$55,460		$58,495	**

Note: Sample excludes pediatricians and physicians working most hours on hospital staff or in emergency room.
Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.
Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at † p<.05 and ‡ p<.01.
Source: 2008 HSC Health Tracking Physician Survey

Resources at Physician's Main Practice. There were no differences across the three PCP subgroups in the availability of health information technology (IT) at the PCP's main practice to support patient care. The most commonly reported IT resources were the use of all electronic medical records (EMR), IT to obtain up-to-date decision support, and IT to access patient notes, medications or problem lists (Fig.3). Close to three-quarters of PCPs in all three groups reported use of all EMR and IT to obtain up-to-date decision support. The only IT resource that high-share Medicare PCPs reported more often than high-share Medicaid PCPs was the capacity to transmit prescriptions electronically to pharmacies.

Fig. 3
Use of Health Information Technology (IT) at Primary Care Physician's Main Practice by Physician's Level of Medicaid Participation, 2008



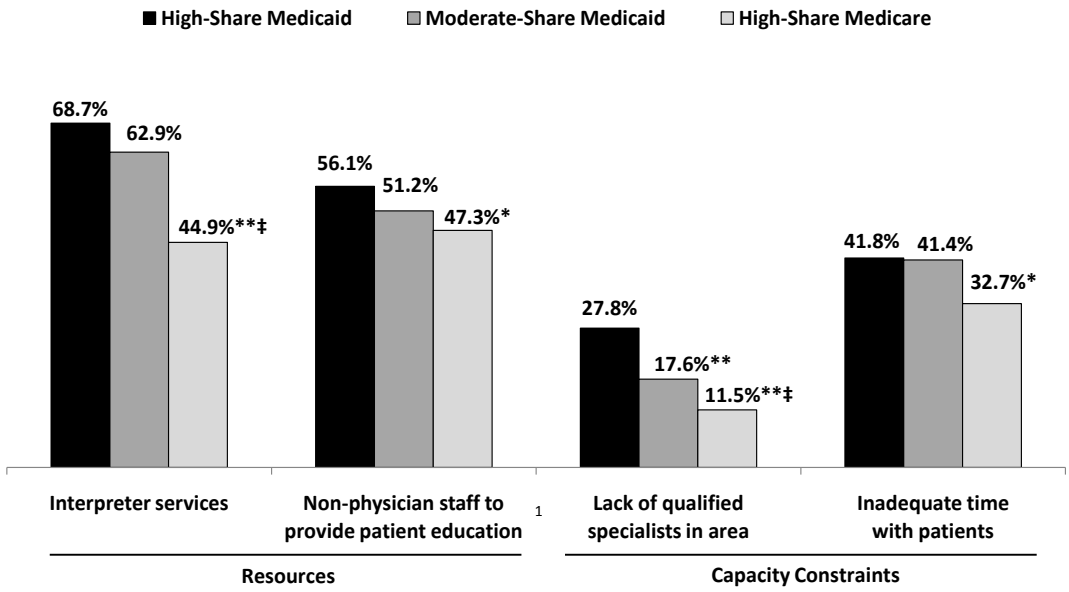
Note: Sample excludes pediatricians and physicians who work most hours on hospital staff or in emergency room.
Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.
Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at †p<.05 and ‡p<.01.
Data source: 2008 HSC Health Tracking Physician Survey

High-share Medicaid PCPs are more likely than high-share Medicare PCPs to provide interpreter services at their main practice (68.7% versus 44.9%) and to use non-physician staff to provide patient education to patients with at least one of four chronic conditions (56.1% versus 47.3%) (Fig.4). There were no statistically significant differences on these measures between high- and moderate-share Medicaid PCPs.

Problems Limiting Ability to Provide High-Quality Care. On the survey, physicians were presented with a list of problems, including a "lack of qualified specialists in your area" and "inadequate time with patients during office visits," that may limit ability to provide high-quality care, and they were asked to indicate if each was a major or minor problem or not a problem. More than a quarter (27.8%) of high-share Medicaid PCPs reported a lack of qualified specialists in the area as a major problem, compared to 17.6% of moderate-share Medicaid and 11.5% of high-share Medicare PCPs. Difficulty finding specialists may reflect problems accessing specialists who accept Medicaid patients, specialist shortages in the practice area, or limitations of the PCP's own network of specialists.

A greater percentage of both high- and moderate-share Medicaid PCPs also reported inadequate time during office visits as a major problem (41.8% and 41.4%), compared to high-share Medicare PCPs (32.7%). Having inadequate time with patients may indicate that physician resources are strained, affecting the quality of care for all patients in the practice. Alternatively, physicians might only limit time with Medicaid patients to account for the lower marginal revenue received from Medicaid.

Fig. 4
Resources and Capacity Constraints at Primary Care Physician's Main Practice by Physician's Level of Medicaid Participation, 2008



[1] Reported to be used for patients with any of four conditions: asthma, diabetes, depression, congestive heart failure.
Note: Sample excludes pediatricians, and physicians working most hours on hospital staff or in emergency room.
Difference from high-share Medicaid PCPs is statistically significant at *p<.05 and **p<.01.
Difference between moderate-share Medicaid and high-share Medicare PCPs is statistically significant at †p<.05 and ‡p<.01.
Data source: 2008 HSC Health Tracking Physician Survey

High-share Medicare PCPs reported spending more time on average in direct patient care (43.8 hours in a typical week) compared to high-share Medicaid (40.7 hours) and moderate-share Medicaid PCPs (41.5 hours)(data not shown). This result could reflect that high-share Medicare PCPs have larger patient panels, work longer hours, or allocate their time differently between patient care and other tasks.

Physician Perspectives on Willingness and Capacity after Health Reform

In in-depth interviews, PCPs were asked how their perspective on accepting more Medicaid patients might change when Medicaid fees are raised. The practice's capacity to serve more Medicaid patients based on its current infrastructure and recent or planned investments, as well as staff cutbacks that could diminish short-term capacity, were discussed.

Willingness. PCPs in practices that currently limit their Medicaid patient panel (moderate-share Medicaid and high-share Medicare PCPs) said they expected that they or their practice's leadership would revisit their Medicaid participation levels, possibly raising caps on Medicaid to a higher percentage of panel representation, from 20% to 25%, for example. However, most cited at least one issue besides payment that they would factor in before accepting more Medicaid patients. These issues were often the same ones that discouraged their participation now, including difficulty finding specialists, paperwork hassles, and the burden of addressing non-medical needs of Medicaid patients.

Several PCPs explained that the decision would depend on the illness burden of new patients. One high-share Medicare PCP said that unless the new Medicaid patients were eligible because of disability, they would be no different from his regular patients. Another PCP indicated that she would reconsider seeing more patients like the relatively healthy Medicaid patients she sees now if she received higher reimbursement, but that she would not reconsider if the new patients were more like her current Medicare patients, who are sicker and need a lot of services. One PCP in solo practice was simply unwilling to see new Medicaid patients.

High-share Medicaid PCPs generally indicated that they would continue to take as many new Medicaid patients as they could and were limited only by the hours they can work. One PCP at a hospital-based clinic noted that, because the clinic already serves a large number of patients who are uninsured now but will likely gain Medicaid coverage in 2014, it did not expect to face much increase in demand under health reform. Other high-share Medicaid PCPs were willing to see more Medicaid patients, but said that doing so would require working very long hours or would increase patient wait times for an appointment.

Short-term Capacity. Both moderate-share Medicaid and high-share Medicare PCPs in varied practice settings described having some infrastructure in place to accept more Medicaid patients in the short-term, or indicated that they would consider hiring a physician assistant or nurse practitioner to accommodate more demand from Medicaid. PCPs in group practices of all sizes who were interviewed reported recent investments by their practices. All had either established EMRs or were now implementing them. Other activities underway or planned included a merger with a local hospital, building satellite clinics, adding evening and weekend hours, and seeking certification as a patient-centered medical home. None of the solo/two-physician practices interviewed had either adopted an EMR or reported recent or planned investments.

Recent Cutbacks in Capacity. Virtually all respondents reported that patients had cut back on office visits as a result of higher unemployment and loss of health insurance experienced in their service areas.[5] However, only two practices had stopped hiring or cut clinical staffing levels. Other practice changes were minor. We interpret statements about available capacity cautiously, because they were offered during a recession when physicians were observing lower overall utilization.

Study Limitations

Data on Medicaid participation drawn from 2008 survey may not be predictive of how physicians will behave under health reform. This study did not quantify the relationship between available PCP resources and projected demand from 16 million additional Medicaid beneficiaries, and so cannot assess the adequacy of the PCP workforce to meet this new demand. To do so will require better measures of physician capacity, as well as data on the geographic access of newly eligible Medicaid beneficiaries to providers who are willing to see them. We lacked data on the size of physicians' patient panels, number of staff employed by the practice, and certain organizational features, such as the availability of after-hours care, that could affect overall capacity.

Discussion

Under health reform, Medicaid enrollment is expected to grow by over 25% by 2019. To help boost the supply of primary care in Medicaid, the health reform law increases Medicaid payment rates for PCPs

temporarily. Additional reforms that may benefit Medicaid include investments in primary care workforce development and in community health centers and the National Health Service Corps.

This study does not project future capacity to absorb increased Medicaid demand for primary care, but it adds to other studies (Doty et al. 2010) indicating that the settings that may offer the most potential new capacity are those where many Medicaid patients currently seek care. PCPs already serving many Medicaid patients (high- and moderate-share Medicaid PCPs) practice in lower-income areas. They are just as likely as others to report resources such as the use of health IT for core patient care purposes, and more likely to offer interpreter services and patient education – key supports for many Medicaid patients. High-share Medicare PCPs are less likely to have these supports and they practice in higher-income areas, both factors that might limit their capacity to see more Medicaid patients even if they were willing.

Nearly four in ten (38%) high-share Medicaid PCPs work in hospital-based practices and community health centers, settings that may have the capacity to expand their Medicaid service. However, there are also indications that some PCPs who currently serve Medicaid actively could face constraints in their capacity to serve more Medicaid patients. Specifically, over a quarter of high- and moderate-share Medicaid PCPs are in solo or two-physician practices; their capacity to see more patients is probably commensurate with the small number of additional hours they could work. Further, the 40% of PCPs in these two groups who currently report inadequate time with patients as a major problem limiting their ability to provide high-quality care will likely face additional difficulty treating more patients and maintaining the same quality of care. Thus, meeting future Medicaid demand for primary care will require recruiting additional Medicaid providers.

PCPs who currently accept few or no new Medicaid patients cite Medicaid payment levels as one of several reasons, but their acceptance of new Medicaid patients in the future will likely hinge on multiple factors, not payment alone. Indeed, other research shows that higher reimbursement is associated with only a small marginal increase in the share of PCPs participating in Medicaid (Cunningham 2011). PCPs are more likely to respond positively if other problems, such as payment delays and prior authorization burden, are addressed, too. Also, payment adjusted for patient complexity could alleviate physician concerns about the uncertain and pent-up health needs of adults newly eligible for Medicaid. In interviews, difficulty finding specialists to see Medicaid patients emerged as a major reason for limiting participation for some PCPs. Thus, low specialist participation in Medicaid may indirectly discourage PCP participation as well.

Another factor likely to influence whether PCPs see more Medicaid patients is practice ownership arrangement. Hospital ownership of a practice can bring enhanced resources (resident staffing) and efficiencies (centralized billing) that can subsidize provision of primary care and potentially increase capacity to accept new Medicaid patients. If more practices are acquired by hospitals, participation dynamics could change and more practices could enter the Medicaid market. Ongoing studies show an emerging trend toward hospital acquisition of primary care and multispecialty group practices (Katz et al. 2010, O'Malley et al. 2011). It is worth monitoring whether this phenomenon expands beyond a few local markets to gauge its implications for PCP participation in Medicaid.

Finally, a broader primary care workforce could help expand the supply of providers seeing Medicaid patients. The ACA includes provisions to expand the supply and role of nurse practitioners and other health professionals, including new funding for nurse-managed health clinics. Interviews with PCPs in

this study suggest that some practices would consider hiring nurse practitioners and physician assistants to expand capacity if it made economic sense, but with the general decline in demand for physician services due to the recession, such action is unlikely in advance of the Medicaid expansion.

This study provides new information regarding PCPs' willingness and capacity to see more Medicaid patients. The finding that PCPs who already serve Medicaid substantially are better-positioned than others, in terms of location and practice resources, to expand their Medicaid service suggests that targeted efforts to increase Medicaid participation in these practices could be more fruitful than efforts to secure broad-based PCP participation in Medicaid. At the same time, it is possible that a period of higher Medicaid payment rates for primary care, along with a much larger Medicaid market, will motivate increased interest in Medicaid among PCPs who have, until now, declined to participate much if at all in the program. In any case, it is safe to say that the expansion of Medicaid coverage presents both new challenges and opportunities for PCPs and others in the primary care workforce as the demand for their services continues to grow.

This issue paper was prepared by Anna S. Sommers of the Center for Studying Health System Change, Julia Paradise of the Kaiser Commission on Medicaid and the Uninsured, and Carolyn Miller, an independent consultant.

Endnotes

[1] A special deduction to income equal to five percentage points of the poverty level raises the effective eligibility level to 138% FPL for non-elderly non-disabled adults.

[2] We further excluded physicians from the sample who reported working in a hospital or medical school and spent most of their time seeing patients in the emergency room or on hospital staff.

[3] Interviews with high-share Medicare PCPs suggest that some who report little or no revenue from Medicaid nonetheless may be treating patients covered by Medicaid because they described their patients as including disabled or elderly individuals dually eligible for Medicare and Medicaid. PCPs could receive reimbursement from Medicare as primary payer for these patients and may not participate in Medicaid as a result.

[4] These physicians identified the place where they worked as a hospital, and in a follow-up question, described the setting as an "office practice owned by the hospital" or "a hospital or medical school clinic." Elsewhere in the report, this setting is described as a "hospital-based practice."

[5] This recent trend has been observed in national data and in most sectors of health care services (Boorady et al. 2010).

Appendix Table 1

Primary Care Physicians' Acceptance of New Patients
by Physician's Level of Medicaid Participation, 2008

	Physician's Level of Medicaid Participation			
	High-share Medicaid	Moderate-share Medicaid	High-share Medicare	Low- and no-share Medicaid
New Medicaid Patients, Percent Accepting:				
All or most	83.6	68.4 **	20.1 ** ‡	8.3 **
Some	10.8	31.6 **	29.0 **	11.3
None	5.6	0.0 **	51.0 ** ‡	80.4 **
New Medicare Patients, Percent Accepting:				
All or most	86.7	82.5	76.8 **	48.1 **
Some	6.6	14.6 **	23.2 ** ‡	22.9 **
None	6.7	2.9 *	0.0 ** ‡	29.1 **
New Private Patients, Percent Accepting:				
All or most	87.8	88.5	85.6	75.2 **
Some	8.3	9.9	10.9	15.4 **
None	3.9	1.6	3.5	9.4 **
Percent Accepting No New Patients	0.4	0.0	0.0	6.8 **

Note: Sample excludes pediatricians and physicians working most hours in inpatient or emergency room.
Asterisks (*) denote a difference from high-share Medicaid PCPs statistically significant at *p<.05 and **p<.01.
† denotes a difference between moderate-share Medicaid and high-share Medicare PCPs statistically significant at † p<.05 and ‡ p<.01.
Source: 2008 HSC Health Tracking Physician Survey

Appendix Table 2

Primary Care Physicians' Practice Revenue from Medicare and Medicaid
by Physician's Level of Medicaid Participation, 2008

	Physician's Level of Medicaid Participation			
	High-share Medicaid	Moderate-share Medicaid	High-share Medicare	Low- and no-share Medicaid
% Revenue from Medicaid				
Zero	0.0	0.0	0.0	59.0
1-5	0.0	0.0	88.0 ** ‡	34.4 **
6-25	0.0	100.0 **	12.0 ** ‡	6.6
26-50	75.1	0.0	0.0	0.0
51-100	24.9	0.0	0.0	0.0
% Revenue from Medicare				
0-10	17.1	11.0 *	0.0 ** ‡	27.6 **
11-25	22.0	23.6	0.0 ** ‡	32.6 **
26-50	47.0	45.4	61.8 ** ‡	28.3 **
51-100	13.9	20.0 *	38.2 ** ‡	11.5
% Revenue from Medicare +Medicaid				
Zero	0.0	0.0	0.0	7.6 **
1-10	0.0	0.9 *	0.0 †	12.4 **
11-25	0.0	10.0 **	0.0 ‡	31.5 **
26-33	0.3	8.4 **	5.0 ** ‡	15.5 **
34-50	9.5	38.6 **	36.5 ** ‡	19.5 **
51-80	53.9	34.3 **	48.7 ‡	12.0 **
>80%	36.3	7.8 **	9.8 ** ‡	1.6 **

Note: Sample excludes pediatricians and physicians working most hours in inpatient or emergency room.

Asterisks (*) denote a difference from high-share Medicaid PCPs statistically significant at *p<.05 and **p<.01.
† denotes a difference between moderate-share Medicaid and high-share Medicare PCPs statistically significant at † p<.05 and ‡ p<.01.

Source: 2008 HSC Health Tracking Physician Survey

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